

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13638

CERTIFICATE OF DEATH

13612

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>22 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Andrew</i> Middle <i>D</i> Last <i>Baden</i>		4. DATE OF DEATH Month <i>12</i> Day <i>2</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/24/04</i>
9. AGE (In years last birthday) <i>56</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>State Road Employee</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>Halbert Baden</i>	
14. MOTHER'S MAIDEN NAME <i>Lucy Murphy</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mabel Baden</i> Address <i>Brandywine, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Hemorrhage (Shock)</i> 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ca. of Rectum -</i> DUE TO (c) <i>abdomino-pelvic Reaction on 11/12/60</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11-7</i> to <i>12-1</i> , 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>12-1</i> 19 <i>60</i> , and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>R de Villarreal</i>		22b. DATE SIGNED <i>12/1/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>R DE VILLARREAL MD</i>		22d. ADDRESS <i>St Leonard</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12-5-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St Peters</i>		23d. LOCATION (City, town, or county) (State) <i>WALDORF, MD.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 6 '60</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

1961

CENTRAL OFFICE

1961

1

1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13639
CERTIFICATE OF DEATH

13613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> d. STREET ADDRESS <u>—</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Randle</u> Last <u>Gray</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1960</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 15, 1869</u>		9. AGE (In years last birthday) <u>91</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Lafayette Broomer Gray</u>				14. MOTHER'S MAIDEN NAME <u>Christiana Bowen</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>217-36644</u>		17. INFORMANT <u>Lyttleton L. Gray, Prince Frederick Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Attack - Adam - Stokes</u> DUE TO <u>Arteriosclerosis C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO <u>—</u> (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1959</u> <u>12/5/60</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 2, 1939</u> , to <u>Dec 15, 1960</u> , that I last saw the deceased alive on <u>Dec 14, 1960</u> , and that death occurred at <u>8 a.m.</u> , from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>Page Jett</u> M.D.				ADDRESS (Street, city or town, state) <u>Prince Frederick Md.</u> DATE SIGNED <u>12/16/60</u>											
PHYSICIAN'S NAME (Type) <u>PAGE JETT</u>				<u>PRINCE FREDERICK</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 18, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Central Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Barstow Calvert Co., Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. A. Harkness, Son, Mutual, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13614**

13640

1. PLACE OF DEATH o. COUNTY <i>Calvert</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Calv.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ches. Beach</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ches. Beach</i>		d. STREET ADDRESS <i>1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Carl</i> Middle <i>Car</i> Last <i>Griffith</i>				4. DATE OF DEATH Month <i>12</i> Day <i>12</i> Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 10, 1892</i>	9. AGE (In years last birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months <i>6</i> Days <i>12</i>	IF UNDER 24 HRS. Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gov.</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Harry Griffith</i>				14. MOTHER'S MAIDEN NAME <i>Cora Louise Ward</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>705-10-9035</i>		17. INFORMANT <i>Mrs Cora Lacing</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Strangulation from hanging</i> DUE TO <i>974X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>suicide</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Found hanging in stairway of house</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hit by car in hallway</i>					
20c. TIME OF INJURY Month, Day, Year <i>12/12/1960</i> Hour <i>9:30</i> o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Ches Beach Calv Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>H W Ward</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>H. W. WARD</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-16-60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt Harmony</i>		22d. LOCATION (City, town, or county) (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home</i>				24a. REC'D BY REGISTRAR <i>DEC 15 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13641 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharing</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Florence</u> First <u>Eros</u> Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u></u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31, 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Saunders</u>		14. MOTHER'S MAIDEN NAME <u>Lucie Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John E. Ross, Drunk</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart not doing at 7:15 PM in bed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. W. Wink</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. Wink</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-19-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>		22d. LOCATION (City, town, or county) (State) <u>AA Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Jr.</u>		ADDRESS <u>Fred.</u>	
24a. REC'D BY REGISTRAR <u>DEC 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

1904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		COLOR <input type="checkbox"/> WHITE <input type="checkbox"/> COLORED	
CAUSE OF DEATH _____		MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE	
TIME OF DEATH _____		PLACE OF DEATH _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE OF EXAMINATION _____		DATE OF DEATH _____	

RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MD
 JAN 10 1904

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13616

Reg. Dist. No.

13642

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olivett md</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Olivett, md.</i> d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Rosie</i> Middle <i>a</i> Last <i>Gross</i>		4. DATE OF DEATH Month <i>12</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 1878</i>
9. AGE (In years lost birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Mathew Sutton</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Buck</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Colonel Gross, Olivett, md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL SCLEPOSIS</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 6</i> , 19 <i>60</i> , to <i>Dec 11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Dec 2</i> , 19 <i>60</i> , and that death occurred at <i>8:15</i> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Page C. Jett</i> <i>Prince Frederick</i> <i>12/12/60</i> ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) <i>PAGE C. JETT</i> <i>BRINCE FREDERICK, MD</i>			
22a. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell, Prince Fred.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 22 60</i>	
24b. REGISTRAR'S SIGNATURE <i>William S. Thayer</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

1913

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13643

13617

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Janie Middle S. Last Grover				4. DATE OF DEATH Month December Day 14 Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1882		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stevens G. Stallings				14. MOTHER'S MAIDEN NAME Priscilla T. Sunderland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address Andrew W. Grover, Owings, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C.V.R. disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/4/48 to 12/14 , 19 60 that (I) (we) last saw the deceased alive on 12/14 , 19 60 and that death occurred at A M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. George J. Weems				22b. DATE SIGNED 11/14/60		22c. PHYSICIAN'S NAME (Type) Dr. George J. Weems	
22d. ADDRESS Owings Huntingtown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 17, 1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Cemetery		23d. LOCATION (City, town, or county) (State) Owings, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home Owings Ind.				25a. REC'D BY REGISTRAR DATE DEC 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13644

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G277 12-27-60 et

Reg. Dist. No. 13618

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b <u>Waldorf</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Chas</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> d. STREET ADDRESS <u>084-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles E. HANNON</u> First <u>Charles</u> Last <u>HANNON</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/67</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Ches E, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Hannon</u>		14. MOTHER'S MAIDEN NAME <u>Sarah (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital</u>		Address <u>Calvert County Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular renal disease & fractures hip 13 days ago</u> DUE TO <u>Fall</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fall</u> DUE TO <u>Fall</u> (c) <u>Fall</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hip and fractured ribs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in walkway house Calvert Md</u>	
20c. TIME OF INJURY Month, Day, Year <u>11/27/60</u> Hour <u>3</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Prince George's</u> (County) <u>Calvert</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. Ward</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bumpy Oak Cemetery</u>
		22d. LOCATION (City, town, or county) <u>Pomonkey, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc. - La Plata, Md.</u>		ADDRESS <u>La Plata, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 20 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hannon</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13619

13645

1. PLACE OF DEATH a. COUNTY <u>CALVERT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CALVERT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCE FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCE FREDERICK (RURAL)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CALVERT COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAURICE E. HUTCHINS</u>		4. DATE OF DEATH Month Day Year <u>DEC. 8, 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 5, 1903</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>CALVERT COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY HUTCHINS</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA CRAWFORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>HAZEL HUTCHINS - PR. FREDERICK</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERFORATED GASTRIC ULCER</u> 722.0 DUE TO <u>CORTISONE THERAPY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>for RHEUMATOID ARTHRITIS</u> DUE TO (c) <u>109 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>1 year</u> <u>109 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 6, 1960</u> , to <u>Dec 8, 1960</u> , that I last saw the deceased alive on <u>Dec 8, 1960</u> , and that death occurred at <u>3:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u> M.D.		ADDRESS (Street, city or town, state) <u>Prince Frederick, Md.</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>		DATE SIGNED <u>12/9/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 11, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ASBURY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BARSTOW - CALVERT CO - MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.O. Harkness & Son - Mutual, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 12 1960</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hand</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

IN U.S.A.
COUNTY OF
BALTIMORE

Name of Deceased _____		Date of Death _____	
Age of Deceased _____		Sex of Deceased _____	
Usual Residence _____		Place of Death _____	
Cause of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Certificate _____		Office of Registrar _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13646

CERTIFICATE OF DEATH

Reg. Dist. No.

13620

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bushy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bushy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>C</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <u>71</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Drusilla Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>X</u> (If yes, give war or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary C. Johnson</u>		Address <u>Bushy, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C.V.R. disease</u> <u>442 X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>12-10</u> , 19 <u>60</u> , to <u>12-24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12-24</u> , 19 <u>60</u> , and that death occurred at <u>12:20</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____			
PHYSICIAN'S NAME (Type) _____			
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>12-28, 60</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	22d. LOCATION (City, town, or county) <u>Bushy</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u>		ADDRESS <u>Pinnae Frederick</u>	
24a. REC'D BY REGISTRAR <u>JAN 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13647

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13621

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunderland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Victoria</u> First <u>Jones</u> Middle <u>Jones</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u></u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>		9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Bud Jones</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Prue Jones</u> Address <u>Sunderland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular and disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Age</u> (c) <u></u> DUE TO (a) <u></u> (b) <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Died at home 1:50 pm</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>HW Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-29-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Sunderland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. E. Sewell, Prince Frederick</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13648

CERTIFICATE OF DEATH

13622

1. PLACE OF DEATH a. COUNTY CALVERT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY CALVERT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUNTINGTOWN		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUNTINGTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) —				d. STREET ADDRESS —			
3. NAME OF DECEASED (Type or print) First LILLIE Middle GIBSON Last LYONS				4. DATE OF DEATH Month DEC. Day 22 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 24, 1871	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months — Days —	IF UNDER 24 HRS. Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL L. GIBSON			14. MOTHER'S MAIDEN NAME SARAH JANE LYONS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO		17. INFORMANT SAMUEL LYONS - P. FREDERICK, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) AURICULAR FIBRILLATION DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma (epithelioma) of lungs						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1935	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 2 , 19 60 , to Dec 22 , 19 60 , that (I) (we) last saw the deceased alive on 12/18 , 19 60 , and that death occurred at 9 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Page C. Jett M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/23/60		
22c. PHYSICIAN'S NAME (Type) PAGE C. JETT M.D.			22d. ADDRESS PRINCE FREDERICK MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC. 26, 1960	23c. NAME OF CEMETERY OR CREMATORY MIRANDA CEMETERY		23d. LOCATION (City, town or county) (State) HUNTINGTOWN, MD.			
24. FUNERAL DIRECTOR'S SIGNATURE A.A. HARKNESS & SON - MUTUAL, MD			ADDRESS —		25a. REC'D BY REGISTRAR DEC 28 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

13043

13043

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
13649
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13623

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>14 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Mabel</i> First Middle Last <i>Pardoe</i>		4. DATE OF DEATH Month <i>December</i> Day <i>14</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 10, 1891</i>
9. AGE (In years last birthday) <i>69</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Reverdy Jones</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Monnett</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service) <i>—</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>James M. Pardoe</i> Address <i>Lusby, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure due to cerebral thrombosis; enlargement of heart</i> DUE TO (b) <i>—</i> DUE TO (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12/15</i> , 19 <i>60</i> , to <i>12/14</i> , 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>12/14</i> , 19 <i>60</i> , and that death occurred at <i>11:30</i> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Roberto De Villarreal</i>		22b. DATE SIGNED <i>12/15/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Roberto De Villarreal, M.D.</i>		22d. ADDRESS <i>St. Leonard, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 17, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Middleham Chapel Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Lusby, Calvert Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>A.G. Harkness & Son</i>		25a. REC'D BY REGISTRAR <i>—</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	
ADDRESS <i>Mt. Airy, Md.</i>		DATE <i>DEC 19 '60</i>	

13643

13643

OFFICE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1900

REPORT

OF THE

COMMISSIONER

OF HEALTH

FOR THE YEAR

1899

ALBANY:

AND

SYRACUSE:

W. B. E. COMPANY

PRINTERS

1900

NEW YORK

STATE

OF

NEW YORK

DEPARTMENT

OF

HEALTH

REPORT

FOR THE YEAR

1899

ALBANY:

AND

SYRACUSE:

W. B. E. COMPANY

PRINTERS

1900

NEW YORK

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13650

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13624

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b Prince Frederick d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol d. STREET ADDRESS X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First: John Middle: Wesley Last: Riggs				4. DATE OF DEATH Month: December Day: 22 Year: 1960											
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27 1909		9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months: Days: Hours: Min.		11. IF UNDER 24 HRS. Months: Days: Hours: Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Columbus Riggs				14. MOTHER'S MAIDEN NAME Hattie Hall											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 579220452				17. INFORMANT Carrie Riggs Address Bristol, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension C.V. Disease 442X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 11/25 19 60 to 12/22 19 60 , that (I) (we) last saw the deceased alive on 12/22 19 60 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.															
22a. SIGNATURE Dr. Geo. Weems				22b. ADDRESS Huntingtown, Maryland				22c. PHYSICIAN'S NAME (Type) Dr. Geo. Weems		22d. ADDRESS Huntingtown, Maryland		22e. DATE 12/23/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Dec. 26, 60 Union Chapel				23b. DATE THEREOF Dec. 26, 60				23c. NAME OF CEMETERY OR CREMATORY Tracys				23d. LOCATION (City, town, or county) (State) IA			
24. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell, Prince Frederick				25a. REC'D BY REGISTRAR DEC 29 '60				25b. REGISTRAR'S SIGNATURE Arthur L. Kline							

13830

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

OFFICE OF THE CHIEF OF BUREAU

13830



CERTIFICATE OF DEATH

13625

1. PLACE OF DEATH o. COUNTY <u>Calvert</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u>		b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince federal</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dump</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co H</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ronald</u>		First <u>Smith</u> Middle <u>Smith</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 2 1961</u>	
9. AGE (In years lost birthday) yrs. <u>10</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Osborn Smith</u>				14. MOTHER'S MAIDEN NAME <u>Basell Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Convulsion</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchial pneumonia</u> DUE TO (c) <u>Cold</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Birth 2/20 1960</u> to <u>12/22 1960</u> , that (I) (we) last saw the deceased alive on <u>12/20 1960</u> , and that death occurred at <u>4:45 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>H. W. Ward</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Dump MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12 23, 60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Edmunds</u>		23d. LOCATION (City, town, or county) (State) <u>Sunderland, Calvert MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>P. F. Jewell, Prince Frederick</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>DEC 29 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thuma</u>			

2064359XV6

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

18021

NAME OF DECEASED
JAMES J. JONES
AGE
35
SEX
M
RACE
W
DATE OF DEATH
JAN 10 1902
PLACE OF DEATH
NEW YORK
CAUSE OF DEATH
DIPHTHERIA
MANNER OF DEATH
NATURAL

SIGNATURE OF PHYSICIAN
J. J. JONES
SIGNATURE OF REGISTRAR
J. J. JONES
OFFICE OF THE REGISTRAR
NEW YORK

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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13652
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M
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13626

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY CALVERT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick			c. LENGTH OF STAY IN 1b 4 days			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle R. Last Wood		4. DATE OF DEATH Month December Day 13 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1899	9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Wood				14. MOTHER'S MAIDEN NAME R. Virginia Denton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Mrs. Harry Conner, Prince Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema - 420 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Heart failure. DUE TO (c) Crown aneurysm							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/10/60 to 12/13/60 , that (I) (we) last saw the deceased alive on 12-13-1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE R. de Villarreuil		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/15/60			
22c. PHYSICIAN'S NAME (Type) R. de Villarreuil M.D.		22d. ADDRESS St Leonard, Md 17151					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 16, 1960		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City, town, or county) (State) Barstow, Calvert Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE A. A. Harrison & Son, Mutual, Md.				25a. REC'D BY REGISTRAR DEC 19 '60		25b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

1865

STATE OF NEW YORK

1865

MADE IN
NEW YORK